INFORMATION

Income Taxes—Division of Fees

A RECENT RULING by the Bureau of Internal Revenue regarding the taxation of fees that are divided amongst two or more physicians has only partial application in California owing to the "anti-rebate law" in effect in this state.

Briefly, the Bureau of Internal Revenue has ruled that physicians may deduct from their taxable income payments they make for "professional assistance" in conducting their practices, and that likewise physicians may deduct as a business expense payments made to other physicians as compensation for referrals; *provided* that the payment of such "referral fees" does not "frustrate sharply defined national or state policies . . ." In this regard, the Bureau ruling follows the law laid down by the U. S. Supreme Court in *Thomas B. Lilly case,* where it was held that an optical company could deduct rebates paid to physicians who prescribed eye glasses and who referred their patients to the optical company. A major consideration in the U. S. Supreme Court decision permitting the deduction as a business expense of eye glasses rebates was that in the state in which the rebates occurred the rebates were not illegal.

In this connection it must be pointed out that, in California, Sections 650-654 of the Business and Professions Code expressly prohibit the payment or receipt of any unearned consideration or rebate "for referring patients . . . to any person . . ." Therefore, in California it is illegal for one physician to pay another a portion of a fee collected solely as a reward to the physician receiving the payment for having referred a patient to the physician making the payment.

Hence, the recent Bureau of Internal Revenue ruling will not apply in California insofar as "referral rebates" are concerned; such rebates or payments, being in violation of state law, will not be a deductible business expense.

On the other hand, the first part of the Bureau of Internal Revenue ruling to the effect that payments made by physicians to other physicians as compensation for work actually performed are deductible business expense, will apply in California, because our "anti-rebate law" does not apply where the payment is made for services rendered rather than for the act of referral.

California Physicians and Civil Defense

Prepared by Medical and Health Services, State Office of Civil Defense

IN ATTEMPTING to present a view of the medical and public health part of civil defense plans there is, on one hand, the risk of assuming too little familiarity with the subject on the part of physicians and workers in fields allied to medicine—this assumption resulting in a seeming, although unintended, insult to their intelligence—and on the other hand there is the equally likely fault of over-assumption of knowledge with the result that the presentation will not easily be followed or understood. Apologies are therefore offered at the outset for either or both of these offenses.

The California State Civil Defense and Disaster Relief Plan is based upon the California Disaster Act of September 15, 1945, and the Civil Defense Act of October 2, 1950.

The Director of Civil Defense of California, in transmitting the plan to the Governor, pointed out that it is "advisory in character to political subdivisions below state level, in recognition of their autonomy" but that adherence by these subdivisions "to the basic organizational structure and procedures set up will provide the uniformity and standardization essential" to an effective working of the plan in the event of a disaster.

The Governor, in his foreword to the publication of the plan, stresses that it "is based upon the fundamental precepts of civil defense—self-help and mutual aid. It preserves the historic autonomy of the community, but pledges the entire resources of the State in the event of emergency beyond the capabilities of a single community or a group of communities banded together for mutual assistance. Its success depends upon thorough and intelligent planning and full cooperation at all levels of government."

The Medical and Health Services organization and effort are, of course, but a part—a vital part—of the over-all state plan which includes such other—and all of them interrelated, variously interdependent—services as: welfare and evacuation, communications, transportation, utilities, engineering, supply, fire, radiological defense, law enforcement, training and public information services.

The plan assumes:

(a) that war may involve enemy action against the civilian population and property,

(b) that sabotage is a major enemy policy and capability,

(c) that atomic weapons will be employed against the most strategic installations and densely populated areas,

(d) that evacuation of elements of population centers will occur only when there is a threat of sustained heavy enemy air attack or invasion in force.

The total plan is based on the worst combination of disaster circumstances that can reasonably be expected; almost the worst that can be imagined. We all know what can happen to "best laid plans," but if we look upon this plan as a form of insurance to protect the lives and health of the people of California, we need not regret any eventuality that will have made the plan excessive in relation to reality any more than we should regret expenditures on life insurance, car insurance, or fire insurance or fire precautions just because we didn't die or become involved in a collision or because our house was only partially burned down or didn't even have a fire. The plan is adaptable to peacetime disaster as well as to war conditions. In time of war it would contribute greatly to the war effort by saving the lives and conserving the manpower that produces the war potential.

The fundamental problem is the quick expansion of existing medical and public health resources in time of disaster to meet the task of caring for casualties in numbers multiplied many times beyond the capacity of our present resources, and to maintain or restore under the temporary disruption of normal sanitary service and the sudden displacement of possibly hundreds of thousands of persons in the state, the safeguarding of food, milk and water and the employment of other measures to prevent the spread of communicable disease.

An atomic attack will mean a quick overflow of the entire present hospital bed capacity of the state, requiring the immediate establishment of auxiliary hospitals in the vicinities of existing hospitals to provide their additional bed-needs, and of large numbers of improvised hospitals to supplement existing hospitals, in a variety of buildings, such as schools, hotels, motels, universities, and apartment buildings in locations surrounding the stricken areas.

An attack will call for the services of every workable doctor, dentist, nurse, pharmacist, technician, veterinary and mortician in the state, besides the special and limited services of those doctors and nurses who through reasons of health and age are only partially workable. Also, it will call upon many thousands of non-professionals for the work of litter bearers, aides, ambulance drivers, clerical and many other forms of help.

Estimates of casualties, including destruction of medical personnel, and of property damage including destruction of metropolitan hospitals and facilities, are based on what actually happened in the two Japanese cities from two atomic bursts. Since the time of those two bursts a great many American medical minds have been occupied with studies as to what would happen to the populations of American cities similarly attacked; what would happen with no preparation or planning and, as was the case in Japan, no knowledge of how radiation victims could be rescued and radiation fatalities greatly reduced.

Important lessons have come from the war experiences in England where civil defense medical and health organization turned the early chaotic condition into one of great efficiency and smooth order. Even with the conventional "pre-atomic" bombs and rocket bombs that were rained on England there was seen the instant need for a thorough organization of medical and health effort in England and, once it was developed, everyone saw its importance and necessity. In one night, in Coventry, in 1940, bombs killed 22,000 and injured 28,000 persons. Civilian casualties treated at first-aid posts and first-aid mobile units in all of England throughout the entire war amounted to 165,000 persons. But that number would be exceeded in one day in Los Angeles or San Francisco by the dropping of one atomic bomb. This comparison gives some indication of the difference in magnitude of the medical job and the need for civil defense organization in any future war.

This lesson has led, in every city and region of the United States, to a growing force and volume of planning and preparation, all aimed at the goal of minimizing human loss both from casualties in possible bomb areas and from the gathering toll of disease and strain that would follow upon the sudden displacement of enormous numbers of our citizens.

If a task of this magnitude is to be faced realistically, and if the plan, therefore, is to envisage the pressing into service of every unit of medical manpower in the state and the use of every conceivably available item of equipment and facility plus the stockpiling in strategic storehouses of all materials that would be of vital need, then the plan must be statewide with a certain amount of coordination at the center and with a great deal of cooperation and hard work throughout the whole medical structures of the local regions.

This effort must, and does, include such items as:

(a) A survey of all available resources (personnel, supplies, present facilities).

(b) The allocation of available resources under a plan that sees attacked areas helped by the neighboring unattacked areas.

(c) Alternate medical teams to fill the gaps caused by death, injuries and displacement of individuals of present teams.

(d) Agreements for mutual aid.

(e) Selection of auxiliary facility sites.

(f) A "spot map" of existing and auxiliary facilities.

(g) Measures for detection and prevention of spread of communicable diseases.

(h) An adaptation of food, milk, and sanitation practices to fit disaster needs.

(i) Nutrition problems in emergency rations.

(j) Mental hygiene measures in the control of panic and to meet psychological warfare.

(k) Establishment of a record and reporting system.

(l) Maintenance of vital records in the listing, identification and disposition of the dead, with notification of the next of kin.

(m) Training and public information.

(n) Radiological defense, which is so highly specialized as to require a special organization, closely allied to, closely cooperating with the medical and health service, but necessarily separated from it in organization.

Coordination from regional and state levels, both in planning and operation, is, by the very nature of the effort, an inescapable part of a medical and health program for civil defense. To some few members of the medical and allied professions, as well as to some in all other walks of American life, the word "coordinator" has come to have an unsavory connotation, perhaps not wholly undeservedly; it has become a frightening word and, to some few, a fighting word. In speaking of civil defense planning to date, there has been some reference to the "confusion at the top and apathy at the bottom." Both confusion and apathy are regrettable in any part of the structure; neither can be denied; both of them, to the extent that they exist, are such natural human imperfections as to call for no explanation or discussion.

As we emerge from the blueprint stage—and we have well emerged from it—the element of confusion is in a satisfying state of decline and apathy is being replaced by an awakening interest.

As we pass from the talking and paper stage of placing orders for supplies and equipment to the stage of filling storehouses with them—a condition now being realized—and as we pass from nebulous hypothetical medical team organizations and facilities into actual specific set-ups—another condition now in realization—we have reason to hope that we are indeed approaching closer to a goal of medical preparedness. Except for the supplies and the training, everyone's deepest hope is that the whole thing can remain forever on paper.

What can those of the medical and allied professions do about it right now? They can put themselves on more familiar terms with the plan by certain readings. They can join up with units and attend meetings of groups that fit the closest to their individual capabilities and circumstances.

They can be well guided in this by their county medical societies, each of which has a committee for civil defense. Each county medical society has contact with the California Medical Association's Emergency Medical Service Committee, whose duty and desire are to assist and encourage the local county medical groups in civil defense planning. This committee is represented on the Medical Advisory Committee of the Disaster Council for the State of California and cooperates with city and county and state health departments.

Among the items of suggested reading are the two articles by Dr. Justin J. Stein in CALIFORNIA MEDICINE of November 1950 and January 1952, respectively, and the editorial "Civil Defense — An Urgent Medical Problem" in the same journal, December 1950.

Also for recommended reading, study, and reference, there should be listed:

(a) Medical Aspects of Atomic Weapons—Bulletin of the Los Angeles County Medical Association, September 7, 1950.

(b) Civil Defense Against Atomic Attack—U. S. Government Printing Office.

(c) Manual for Organization, Training and Operation of First-Aid Stations, recently issued by the Division of Medical and Health Services of the California State Office of Civil Defense.

(d) Plan for Existing, Auxiliary, and Improvised Hospitals—now on press and shortly to be issued by the California State Office of Civil Defense.

(e) Plan for the Blood Program under Disaster Conditions — Federal Civil Defense Administration —U. S. Government Printing Office.